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# 2000

# STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2000)

#### IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH F		13547		II. CERTI	FICATION BY AUTHORIZED FACILITY OFFICER
Address	520 FABYAN PARKWAY Number	BATAVIA City	60510 Zip Code	State o and cer are true	re examined the contents of the accompanying report to the fillinois, for the period from 01/01/00 to 12/31/00 tify to the best of my knowledge and belief that the said contents e, accurate and complete statements in linear transfer of property (other than provides)
Telepho IDPA I	ne Number: (630) 879-5266  Number: 830320180014	Fax # (630) 879-5214		is base Inter	ble instructions. Declaration of preparer (other than provider) d on all information of which preparer has any knowledge. ntional misrepresentation or falsification of any information cost report may be punishable by fine and/or imprisonment.
	Ownership:  VOLUNTARY,NON-PROFIT	X PROPRIETARY	GOVERNMENTAL	Officer or Administrator of Provider	(Signed) (Date) (Type or Print Name) LARRY BONDS (Title) PRESIDENT
IRS Exc	Charitable Corp. Trust mption Code	Individual Partnership Corporation	State County Other		(Signed)(Date)
		"Sub-S" Corp. X Limited Liability Co. Trust Other		Paid Preparer	(Print Name and Title)  JEFFREY E. BOLAND, DIRECTOR  (Firm Name ZA CONSULTING, LLC & Address)  305 NORTH FRONT ST. HARRISBURG, PA 17101
In the e Name: J	vent there are further questions about EFFREY E. BOLAND	this report, please contact: Telephone Number: (717) 213	3-3125		(Telephone) (717) 213-3125 Fax # (717) 233-4633  MAIL TO: OFFICE OF HEALTH FINANCE  ILLINOIS DEPARTMENT OF PUBLIC AID  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facil	lity Name & ID Numb	oer <u>FIRWOOD I</u>	HEALTH CARE CE	ENTER			# 0043547 Report Period Beginning: 01/01/00 Ending: 12/31/00
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
		with license). Date of		•			
	( <b>g</b>		<b>.</b>	_		_	E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
	<u> </u>			T	<u> </u>		NONE
	Beds at				Licensed		NONE
	Beginning of	Licensu	wo.	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?  YES
	0 0	Level of			•		F. Does the facility maintain a daily midnight census?  YES
	Report Period	Level of	care	Report Period	Report Period		
		CI III I (CI	g).				G. Do pages 3 & 4 include expenses for services or
1		Skilled (SNI				1	investments not directly related to patient care?
2	(2)		atric (SNF/PED)	(2)	22.050	2	YES NO X
3	63	Intermediat		63	23,058	3	
4	Intermediate/DD Sheltered Care (SC)					4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered Care (SC) ICF/DD 16 or Less				5	YES NO X
6		ICF/DD 16 (	or Less			6	I. On what date did you start providing long term care at this location?
7	63 TOTALS			63	23,058	7	
/	03	IUIALS		03	23,058	/	Date started 2/7/98
							T. W. (1. 6. 11)
	P Consus For	r the entire report per	hoi				J. Was the facility purchased or leased after January 1, 1978?  YES X Date 2/7/98 NO
	D. Census-For		3	4	5	1	TES A Date 2/1/96
		2	•	•			T7 337 (1 6 11) (10 16 36 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Level of Care		by Level of Care an	d Primary Source of	Payment	-	K. Was the facility certified for Medicare during the reporting year?  YES  NO  X  If YES, enter number
		Public Aid	D 1 4 D	0.4	TF 4 1		
	CNIE	Recipient	Private Pay	Other	Total		of beds certified and days of care provided
	SNF					8	
	SNF/PED					9	Medicare Intermediary
	ICF	13,626	3,433		17,059	10	W. A GGOVINITING BAGYS
	ICF/DD					11	IV. ACCOUNTING BASIS
12						12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL X CASH* CASH*
14	TOTALS	13,626	3,433		17,059	14	Is your fiscal year identical to your tax year? YES X NO
							<del></del>
		ccupancy. (Column 5,		tal licensed			Tax Year: 12/31 Fiscal Year: 12/31
	bed days of	n line 7, column 4.)	73.98%	_			* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS Page 3 Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

V COST CENTER EXPENSES (throughout the report places round to the poort # 0043547 **Report Period Beginning:** 12/31/00 01/01/00 **Ending:** 

	V. COST CENTER EXPENSES (throug	nout the report,	osts Per Genera	<u>) tne nearest do</u> il Ledger	uar)	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	10110111	COL OTTEL	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	137,576	12,592	3,589	153,757		153,757	(114)	153,643		<u> </u>	1
2	Food Purchase	,	66,698	,	66,698		66,698	,	66,698			2
3	Housekeeping	76,595	9,583	2,266	88,444		88,444		88,444			3
4	Laundry	14,740	3,820	41,859	60,419		60,419		60,419			4
5	Heat and Other Utilities			24,012	24,012		24,012		24,012			5
6	Maintenance	11,518	11,371	27,536	50,425		50,425		50,425			6
7	Other (specify):*											7
8	TOTAL General Services	240,429	104,064	99,262	443,755		443,755	(114)	443,641			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	681,758	44,870	84,729	811,357		811,357	3,096	814,453			10
10a	Therapy			3,300	3,300		3,300		3,300			10a
11	Activities	27,157	1,768	1,345	30,270		30,270		30,270			11
12	Social Services	27,030		1,031	28,061		28,061	37	28,098			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	735,945	46,638	98,205	880,788		880,788	3,133	883,921			16
	C. General Administration											
17	Administrative			93,057	93,057		93,057	10,953	104,010			17
18	Directors Fees											18
19	Professional Services			63	63		63	22,015	22,078			19
20	Dues, Fees, Subscriptions & Promotions			18,447	18,447		18,447	(7,922)	10,525			20
21	Clerical & General Office Expenses	22,194	25,888	29,937	78,019		78,019	26,242	104,261			21
22	Employee Benefits & Payroll Taxes			113,294	113,294		113,294	48,010	161,304			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,955	2,955		2,955	2,424	5,379			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,327	24,327		24,327	14,658	38,985			26
27	Other (specify):*											27
28	TOTAL General Administration	22,194	25,888	282,080	330,162		330,162	116,380	446,542			28
20	TOTAL Operating Expense	998,568	176,590	479,547	1,654,705		1,654,705	119,399	1,774,104			29
4)	(sum of lines 8, 16 & 28)				, ,		1,037,703	117,377	1,77,104			4)

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0043547

# V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			56,487	56,487		56,487		56,487			30
31	Amortization of Pre-Op. & Org.			212,642	212,642		212,642	(204,242)	8,400			31
32	Interest			262,212	262,212		262,212		262,212			32
33	Real Estate Taxes			28,135	28,135		28,135		28,135			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,110	5,110		5,110		5,110			35
36	Other (specify):* Mtg. Guarantee			54,778	54,778		54,778		54,778			36
37	TOTAL Ownership			619,364	619,364		619,364	(204,242)	415,122			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177	1,818	1,995		1,995		1,995			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177	36,406	36,583		36,583		36,583			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	998,568	176,767	1,135,317	2,310,652		2,310,652	(84,843)	2,225,809			45

<sup>\*</sup>Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

# 0043547

**Report Period Beginning:** 

01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	III COLUMN 2	below, refere	nce the n	ine on wi	nich the particula	ir cost
	MANI ALLAWADI E EVDENCES	1	4	Refer-	OHF USE ONLY	
1	NON-ALLOWABLE EXPENSES	Amo	unt	ence		1
2	Day Care	\$			\$	1 2
	Other Care for Outpatients					
3	Governmental Sponsored Special Programs Non-Patient Meals		(11.1)	1		3
4			(114)	1		4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation					9
10	Interest and Other Investment Income					10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
16	Personal Expenses (Including Transportation)					16
17	Non-Care Related Fees					17
18	Fines and Penalties					18
19	Entertainment					19
20	Contributions					20
21	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional		(7,922)	20		25
	Income Taxes and Illinois Personal		( ) )		1	<del>                                     </del>
26	Property Replacement Tax					26
27	Nurse Aide Training for Non-Employees					27
28	Yellow Page Advertising					28
29	Other-Attach Schedule	(	212,476)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (	220,512)		\$	30

	<b>OHF USE ONL</b>	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

			1	2	
		A	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$			31
32	Donated Goods-Attach Schedule*				32
	Amortization of Organization &				
33	Pre-Operating Expense				33
	Adjustments for Related Organization				
34	Costs (Schedule VII)		135,669	VAR	34
35	Other- Attach Schedule				35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	135,669		36
	(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$	(84,843)		37

<sup>\*</sup>These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

1 2 3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

Sch. V Line

	NON-ALLOWABLE EXPENSES	Amount	Reference	
1	AMORT - GOODWILL	S (204,242)	31	1
2	BUSINESS MEALS	(1,169)	21	2
3	FINES/PENALTIES	(7,065)	21	3
4				4
5				5
6				6
7				7
9				9
10 11				10 11
12				12
13				13
14				14
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72				72
73 74				73 74
75				75
76				76
77 78				77 78
78				78
80				80
81				81
82				82
83				83
84				84
85				85
86				86
		1		87
87				
88				88
88 89	Total	(212,476)		

01/01/00

**Ending:** 

12/31/00

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

# 0043547 Report Period Beginning:

	SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I												
	SUMMARY OF PAGES 5, 5A, 6, 6A	1, бв, бС, бр,	6E, 6F, 6G, 6F	1 AND 61	ı				1		1		CID CI CID
													SUMMARY
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н		(to Sch V, col.7)
1	Dietary	(114)	0	0	0	0	0	0	0	0	0	0	(114) 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	-
8	TOTAL General Services	(114)	0	0	0	0	0	0	0	0	0	0	(114) 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	3,096	0	0	0	0	0	0	0	0	0	3,096 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	37	0	0	0	0	0	0	0	0	0	_
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	3,133	0	0	0	0	0	0	0	0	0	3,133 16
	C. General Administration												
17	Administrative	0	10,953	0	0	0	0	0	0	0	0	0	10,953 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	0	0	22,015	0	0	0	0	0	0	0	0	22,015 19
20	Fees, Subscriptions & Promotions	(7,922)	0	0	0	0	0	0	0	0	0	0	(7,922) 20
21	Clerical & General Office Expenses	(8,234)	1,373	33,103	0	0	0	0	0	0	0	0	26,242 21
22	Employee Benefits & Payroll Taxes	0	0	48,010	0	0	0	0	0	0	0	0	48,010 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	0	2,424	0	0	0	0	0	0	0	0	0	2,424 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	14,658	0	0	0	0	0	0	0	0	,
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 27
28	TOTAL General Administration	(16,156)	14,750	117,786	0	0	0	0	0	0	0	0	116,380 28
	TOTAL Operating Expense	,	·										
29	(sum of lines 8,16 & 28)	(16,270)	17,883	117,786	0	0	0	0	0	0	0	0	119,399 29

# **SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	<b>6E</b>	<b>6F</b>	6 <b>G</b>	6H	<b>6I</b>	(to Sch V, col.7)	)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(204,242)	0	0	0	0	0	0	0	0	0	0	(204,242)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(204,242)	0	0	0	0	0	0	0	0	0	0	(204,242)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(220,512)	17,883	117,786	0	0	0	0	0	0	0	0	(84,843)	45

0043547

**Report Period Beginning:** 

#### VII. RELATED PARTIES

**Facility Name & ID Number** 

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

	(1000 000 000 000 000 000 000 000 000 00			· · · · · · · · · · · · · · · · · · ·		
	2			3		
	RELATED NURSI	ING HOMES	OTHER REL	ATED BUSINESS EN	TITIES	
Ownership %	Name	City	Name	City	Type of Business	
	SEE ATTACHED LIST		EDEN & ASSOC, INC	WILSON, WY	CONSULTING	
	Ownership %	2 RELATED NURS	2 RELATED NURSING HOMES Ownership % Name City	2 RELATED NURSING HOMES Ownership % Name City Name	Ownership % Name City Name City	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, X YES management fees, purchase of supplies, and so forth. NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	10	Contract Services - RN	\$	Senior Living Properties, LLC	100.00%	\$ 329	\$ 329	1
2	V	10	Contract Services - RN		Senior Living Properties, LLC	100.00%	1,265	1,265	2
3	V	10	Contract Services - RN	11,805	Senior Living Properties, LLC	100.00%	13,307	1,502	3
4	V	12	Social Services Consultant	1,031	Senior Living Properties, LLC	100.00%	1,068	37	4
5	V	17	<b>Contract Services - Business Office</b>	e 32,770	Senior Living Properties, LLC	100.00%	39,968	7,198	5
6	V	17	<b>Contract Services - Administrator</b>	60,287	Senior Living Properties, LLC	100.00%	64,042	3,755	6
7	V	24	Travel	2,046	Senior Living Properties, LLC	100.00%	4,358	2,312	7
8	V	21	<b>Business Meals</b>	1,169	Senior Living Properties, LLC	100.00%	1,377	208	8
9	V	24	Seminars	909	Senior Living Properties, LLC	100.00%	1,021	112	
10	V	21	Office Supplies	21,020	Senior Living Properties, LLC	100.00%	21,328	308	10
11	V	21	Supplies	3,679	Senior Living Properties, LLC	100.00%	3,738	59	11
12	V	21	Postage	1,189	Senior Living Properties, LLC	100.00%	1,201	12	
13	V	<b>21</b>	Telephone	16,134	Senior Living Properties, LLC	100.00%	16,920	786	13
14	Total			\$ 152,039			\$ 169,922	\$ * 17,883	14

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

# 0043547

### VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	21	EDP Services	\$	Senior Living Properties, LLC	100.00%			15
16	V	19	Legal Fees	63	Senior Living Properties, LLC	100.00%	7,692	7,629	16
17	V	19	Accounting Fees		Senior Living Properties, LLC	100.00%	14,386	14,386	17
18	V	<b>26</b>	Insurance - General Liability	21,545	Senior Living Properties, LLC	100.00%	24,147	2,602	18
19	V		Insurance - Property & Contents	2,482	Senior Living Properties, LLC	100.00%	14,430	11,948	19
20	V		Insurance - Other	300	Senior Living Properties, LLC	100.00%	408	108	20
21	V		Workers Compensation Claims	36,666	Senior Living Properties, LLC	100.00%	73,263	36,597	21
22	V		Health & Dental Insurance		Senior Living Properties, LLC	100.00%	11,413	11,413	22
23	V	<b>21</b>	Management Fees		Senior Living Properties, LLC	100.00%	29,617	29,617	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 61,056			\$ 178,842	\$ * 117,786	39

<sup>\*</sup> Total must agree with the amount recorded on line 34 of Schedule VI.

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### VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Ho	urs Per Work				
					Compensation	Week Dev	oted to this	Compensation	on Included	Schedule V.	
					Received	Facility and	d % of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	k Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9				_							9
10											10
11											11
12				_							12
13								TOTAL	\$		13

<sup>\*</sup> If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

<sup>\*\*</sup> This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Page 8 **Facility Name & ID Number** FIRWOOD HEALTH CARE CENTER 0043547 Report Period Beginning: 01/01/00 **Ending:** 12/31/00

# VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office YES X or parent organization costs? (See instructions.) NO

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SENIOR LIVING PROPERTIES, LLC **Street Address** 3395 NORTH PINES DRIVE, SUITE 102 WILSON, WYOMING 83014 City / State / Zip Code

Phone Number (307) 739-1209 Fax Number (307) 739-1217

	1	2	3	4	5	6	7	8	9	
	Schedule V		<b>Unit of Allocation</b>		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		<b>Subunits Being</b>	<b>Cost Being</b>	<b>Cost Contained</b>	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	\$ 13,034	\$	17,059	\$ 329	1
2	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	50,078		17,059	1,265	2
3	10	Contract Services - RN	Resident Days (IL Only)	675,434	31	59,476		17,059	1,502	3
4			<b>Resident Days (IL Only)</b>	675,434	31	1,475		17,059	37	4
5	17	Contract Services - Business Offic	Resident Days (Total)	1,728,555	88	729,382		17,059	7,198	5
6	17	Contract Services - Administrator		675,434	31	148,670		17,059	3,755	6
7	24	Travel	Resident Days (IL Only)	675,434	31	91,552		17,059	2,312	7
8	21	Business Meals	Resident Days (IL Only)	675,434	31	8,225		17,059	208	8
9	24	Seminars	Resident Days (IL Only)	675,434	31	4,452		17,059	112	9
10	21	Office Supplies	Resident Days (IL Only)	675,434	31	12,185		17,059	308	10
11	21	Supplies	Resident Days (IL Only)	675,434	31	2,350		17,059	59	11
12	21	Postage	<b>Resident Days (IL Only)</b>	675,434	31	466		17,059	12	12
13	21	Telephone	Resident Days (IL Only)	675,434	31	31,125		17,059	786	13
14	21	EDP Services	<b>Resident Days (IL Only)</b>	675,434	31	138,040		17,059	3,486	14
15	19	Legal Fees	<b>Resident Days (Total)</b>	1,728,555	88	737,379		17,059	7,277	15
16	19	Accounting Fees	<b>Resident Days (Total)</b>	1,728,555	88	1,457,713		17,059	14,386	16
17	26	Insurance - General Liability	<b>Resident Days (Total)</b>	1,728,555	88	263,635		17,059	2,602	17
18	26	<b>Insurance - Property &amp; Contents</b>	<b>Resident Days (Total)</b>	1,728,555	88	1,210,642		17,059	11,948	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924		17,059	108	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015		17,059	3,257	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469		17,059	11,413	21
22	21		Resident Days (Total)	1,728,555	88	1,721,509		17,059	16,989	22
23	19	Legal Fees	<b>Resident Days (IL Only)</b>	675,434	31	13,948		17,059	352	23
24	22	Workers Compensation Claims	Resident Days (IL Only)	675,434	31	1,320,062		17,059	33,340	24
25	TOTALS					\$ 9,512,806	\$		\$ 123,041	25

STATE		

IS Page 8A **Facility Name & ID Number** FIRWOOD HEALTH CARE CENTER 0043547 Report Period Beginning: 01/01/00 **Ending:** 12/31/00

# VIII. ALLOCATION OF INDIRECT COSTS

			Name of Related Organization	SENIOR LIVING PROPERTIES, LLC
A. Are there any costs included in this report which were	derived from allocation	s of central office	<b>Street Address</b>	3395 NORTH PINES DRIVE, SUITE 10
or parent organization costs? (See instructions.)	YES X	NO	City / State / Zip Code	WILSON, WYOMING 83014
			Phone Number	( (307) 739-1209

B. Show the allocation of costs below. If necessary, please attach worksheets.

City / State / Phone Numb Fax Number	er (	WILSON, WY (307) 739-1209 (307) 739-1217		
6 Total Indirect	7 Amount of Salary	8	9	
<b>Cost Being</b>	Cost Contained	Facility	Allocation	
Allocated	in Column 6	Units	(col.8/col.4)x col.6	

	1	2	3	4	5		6	7	8	9	
	Schedule V		Unit of Allocation		Number of	7	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		<b>Subunits Being</b>		<b>Cost Being</b>	<b>Cost Contained</b>	Facility	Allocation	
	Reference	Item	Square Feet)	<b>Total Units</b>	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	21	Management Fees	Resident Days (IL Only)	675,434		\$		\$	17,059		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25	TOTALS					\$	500,000	\$		\$ 12,628	25

FIRWOOD HEALTH CARE CENTER

# 0043547

**Report Period Beginning:** 

01/01/00

**Ending:** 

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# IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	•	3	4	5	,	6	7	8	9	10	
	Name of Lender	Relate		Purpose of Loan	Monthly Payment	Date of			int of Note	Maturity Date	Interest Rate	Reporting Period Interest	
		YES	NO		Required	Note		Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related												
	Long-Term						1						
1	GMAC COMM. MORT. CORP		X	ACQUISITION	\$20,599.00		\$	3,007,608		2/1/08	0.0681		1
2	CCS NOTE		X	ACQUISITION	\$776.00			133,080	133,080		0.0700	16,712	2
3	SEE ATTACHED		X	ACQUISITION	\$776.00	2/6/98		133,080	133,080	2/6/08	0.0700	16,712	3
4													4
5													5
	Working Capital												
6	HEALTH CARE FINANCIAL	PART	X	WORKING CAPITAL	NONE	2/6/98		42,550	56,529	DEMAND	PRIME + 2	2% 25,944	6
7													7
8													8
	TOTAL F. 224. D.L.4. J				622 151 00		0	2 217 210	0 2 120 147			o 262.212	
9	TOTAL Facility Related				\$22,151.00		2	3,316,318	\$ 3,138,147			\$ 262,212	9
1.0	B. Non-Facility Related*				1	T	T		T	ı	1		10
10													10
11													11
12													12
13													13
14	TOTAL Non Facility Polated						•		<b>C</b>			<b>C</b>	14
14	TOTAL Non-Facility Related						•		<b>3</b>	-		<b>J</b>	14
15	TOTALS (line 9+line14)						s	3,316,318	\$ 3,138,147			\$ 262,212	15

<sup>\*</sup> Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

<sup>\*\*</sup> If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER # 0043547 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

B. Real Estate Taxes				1		$\overline{}$
Real Estate Tax accrual used on 1999 report				\$	19,310	1
	icate the tax year to which this payment applies. If payment co	overs more than one year, de	tail below.)	\$	28,135	
3. Under or (over) accrual (line 2 minus line 1)	).			\$	8,825	3
4. Real Estate Tax accrual used for 2000 repor	t. (Detail and explain your calculation of this accrual on the lin	nes below.)		\$	19,310	4
	which has NOT been included in professional fees or other ge			\$		5
amount of any direct appeal costs classified	reviously to calculate a payment rate. You must offset the full as a real estate tax cost plus one-half of any remaining refund.  or 19 Tax Year. (Attach a copy of the		board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedu	ale V, line 33. This should be a combination of lines 3 thru 6.			\$	28,135	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1995 27,135 8		FOR OHF USE ONLY			
	1996 27,433 9 1997 27,605 10	13	FROM R. E. TAX STATEMENT FC	R 1999 \$		13
	1998     27,998     11       1999     28,135     12	14	PLUS APPEAL COST FROM LINE	5 \$		14
		15	LESS REFUND FROM LINE 6	\$		15
		16	AMOUNT TO USE FOR RATE CAI	CUI ATION S		16

**NOTES:** 

- 1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

. BUILDING AND GENERAL I	INFORMATION:					
A. Square Feet:	14,290 B. General Construction Typ	e: Exterior B	RICK Fr	ame WOOD	Number of Stories	1
C. Does the Operating Entity:	? X (a) Own the Facility	(b) Rent from a R	delated Organization.		(c) Rent from Completely Unrel Organization.	ated
(Facilities checking (a) or (	b) must complete Schedule XI. Those checking	g (c) may complete Schedule X	I or Schedule XII-A. See	instructions.)	organization.	
D. Does the Operating Entity	? X (a) Own the Equipment	(b) Rent equipme	nt from a Related Organi	zation.	X (c) Rent equipment from Compl Unrelated Organization.	letely
(Facilities checking (a) or (	b) must complete Schedule XI-C. Those check	ing (c) may complete Schedule	XI-C or Schedule XII-B.	See instructions.)		
(such as, but not limited to	ties owned by this operating entity or related to , apartments, assisted living facilities, day train usiness, square footage, and number of beds/ur	ning facilities, day care, indepe	endent living facilities, nu			
F. Does this cost report reflec If so, please complete the fo	t any organization or pre-operating costs whic	h are being amortized?		YES	X NO	
1. Total Amount Incurred:	Ü	2.	Number of Years Over V	Vhich it is Being Am	ortized:	
3. Current Period Amortization	on:	4.	Dates Incurred:			
	Nature of Costs: (Attach a complete schedule	detailing the total amount of o	rganization and pre-oper	ating costs.)		
I. OWNERSHIP COSTS:						
A T and	1	2 Samura Frant	3	4 Cast		
A. Land.	Use 1 FACILITY	Square Feet 79,279	Year Acquired 1998 \$	Cost 58,230	1	
	2	17,217	1770 \$	30,230	2	
	3 TOTALS	79,279	S	58,230	) 3	

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

STATE OF ILLINOIS

# 0043547 Report Period Beginning:

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STATE OF ILLINOIS

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**Report Period Beginning:** 

01/01/00 Ending:

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**Facility Name & ID Number** FIRWOOD HEALTH CARE CENTER

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ng Depreciation-including fixed Eq	2	3	4	5	6	7	8	9	
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	63		1998	1972	\$ 860,205	\$ 28,674	10	\$ 28,674	\$	\$ 83,631	4
5											5
6											6
7											7
8											8
	Impro	vement Type**									
	REPAIR FUR			1998	1,600	107	15	107		231	9
		NSTALLATION		1998	8,500	567	15	567		1,606	10
	CARPET EX	FRACT		1998	1,044	209	5	209		452	11
12				4000						4.50	12
	SIGNAGE			1998	464	46	15	46		120	13
	ASPHALT IN			1998	11,760	1,470	8	1,470		3,430	14
	DRAINAGE S			1998	13,000	867	15	867		1,950	15
		OVEMENT (PURCHASE PRICE)		1998	24,298	1,620	15	1,620		4,725	16
		HOWER ROOM		1999	18,692	935	20	935		1,713	17
	WOOD FLOO			1999	3,425	171 342	20	171		300	18
	CONCRETE			1999 1999	6,845		20	342		485	19
	SUPPORT BI SEED AND F			1999	3,890 1,945	195 195	20 10	195 195		276 276	20 21
		W/ BAR GRADE		1999	4,472	179	25	179		253	21
22	WAN HOLE	W/ DAK GRADE		1999	4,472	179	23	1/9		255	23
_	RIII DINC II	MPROVEMENT		2000	1,302	29	15	29		29	24
25	BUILDING II	WI KOVEMENT		2000	1,502	2)	13	2)		2)	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (line	es 4 thru 35)			\$ 961,442	\$ 35,606		\$ 35,606	\$	\$ 99,477	36

<sup>\*</sup>Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number FIRWOOD HEALTH CARE CENTER # 0043547 Report Period Beginning: 01/01/00 Ending: 12/31/00

# XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	st Equipment Depreciation Excluding Transportations (See instructions)										
	Category of		1		Current Book	Straight Line	4	Component	Accumulated		
	Equipment		Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6		
37	Purchased in Prior Years	\$	161,571		\$ 20,881	\$ 20,881	\$	<b>VARIOUS</b>	\$ 54,857	37	
38	Current Year Purchases									38	
39	Fully Depreciated Assets		50.00							39	
40										40	
41	TOTALS	\$	161,571		\$ 20,881	\$ 20,881	\$		\$ 54,857	41	

# D. Vehicle Depreciation (See instructions.)\*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

#### E. Summary of Care-Related Assets

	E. Summary of Care-Related Assets	1	<b>=</b>		
		Reference	Amount		]
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,181,243	47	]
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 56,487	48	]
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 56,487	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 154,334	51	1

# F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

			8 \		
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

# G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

STATE	OΕ	ILLINOIS
SIAIL	OF	ILLINOIS

Faci	lity Name & I	D Number	FIRWOOD HEALT	H CARE CENTI		ΓE OF ILLINOIS 0043547		eriod B	eginning:	01/01/00	Ending:	Page 14 12/31/00
XII.	<ol> <li>Name of I</li> <li>Does the :</li> </ol>	nd Fixed Equipn Party Holding Le		CABLE	ount shown below on line 7	, column 4?  YES	]NO				5	
		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*					
3	Original Building: Additions			\$				3 4		dates of current	_	nent:
5					NOT APPLICABLE			5	g			
7	TOTAL			\$	**			7	11. Rent to be rental agi	e paid in future reement:	years under t	he current
	This amo	unt was calculatength of the lease	zation of lease expense d by dividing the total  YES  X	amount to be an		*			12	/2001 /2002 /2003	Annual Re	nt 
	15. Is Mova	ble equipment re	nsportation and Fixed I ntal included in building ble equipment: \$	Equipment. (See ng rental?			]NO 41; SCAFFOLDING	ΓRUCK	- \$2,395			
	C. Vehicle R	ental (See instruc	tions.)			(Attach a schedu	le detailing the breakd	lown of	movable equipmo	ent)		

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			NOT APPLICABLE		19
20					20
21	TOTAL		<b>\$</b>	\$	21

<sup>\*</sup> If there is an option to buy the building, please provide complete details on attached schedule.

<sup>\*\*</sup> This amount plus any amortization of lease expense must agree with page 4, line 34.

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Page 15 0043547 12/31/00 **Facility Name & ID Number** FIRWOOD HEALTH CARE CENTER **Report Period Beginning:** 01/01/00 Ending:

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

	. TYPE OF TRAINING PROGRAM (If aides are train	`	,	sahadula listing t	ho facility name ad	dross and gost nor aids trained in that facility
A	1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	YES 2  X NO		1 PORTION:		3. CLINICAL PORTION:  IN-HOUSE PROGRAM
	If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN OTHER FA	Y COLLEGE		IN OTHER FACILITY HOURS PER AIDE
В	. EXPENSES	ALLOCATI 1	ON OF COSTS	(d) 3	4	C. CONTRACTUAL INCOME  In the box below record the amount of income your facility received training aides from other facilities.
		Fa	cility			
		Drop-outs	Completed	Contract	Total	\$
	1 Community College Tuition	\$	\$	\$	\$	
	2 Books and Supplies					D. NUMBER OF AIDES TRAINED
	3 Classroom Wages (a)					GOMPA EMED
	4 Clinical Wages (b)					COMPLETED
	5 In-House Trainer Wages (c)				_	1. From this facility
	6 Transportation					2. From other facilities (f)
	7 Contractual Payments					DROP-OUTS
	8 Nurse Aide Competency Tests		1			1. From this facility

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

9 TOTALS

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

# 2. From other facilities (f) TOTAL TRAINED

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(Since Such as a	1	2	3	4	5	6	7	8	
		Schedule V	Staff	f	Outsid	le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	<b>Total Units</b>	<b>Total Cost</b>	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language									
2	Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	<b>Licensed Physical Therapist</b>		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39.3	prescrpts			30	5		35	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	<b>Academic Education</b>		hrs							11
12	Exceptional Care Program									12
13	Other (specify): ANCILLARY SVC.	39.2, 39.3					1,960		1,960	13
14	TOTAL			\$		\$ 30	\$ 1,965		\$ 1,995	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS Page 17 0043547 **Report Period Beginning:** 01/01/00 12/31/00 **Ending:** 

**Facility Name & ID Number** FIRWOOD HEALTH CARE CENTER

As of 12/31/00 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	This report must be completed even	1		2 After	
		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	2,300	\$	1
2	Cash-Patient Deposits		40,205		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance 30,404)		212,980		3
4	Supply Inventory (priced at COST )		16,123		4
5	Short-Term Investments				5
6	Prepaid Insurance		(8,838)		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	262,770	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		58,230		13
14	Buildings, at Historical Cost		933,435		14
15	Leasehold Improvements, at Historical Cost		55,939		15
16	Equipment, at Historical Cost		133,639		16
17	Accumulated Depreciation (book methods)		(154,334)		17
18	Deferred Charges		1,800,619		18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	2,827,528	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	3,090,298	\$	25

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	148,217	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		40,205		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable				30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)		19,310		32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	INTER CO SLP TEXAS		1,244,954		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	1,452,686	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable		3,138,147		39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	3,138,147	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	4,590,833	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	(1,500,535)	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	3,090,298	\$	48

\*(See instructions.)

0043547 Report Period Beginning: 01/01/00

1/00 Ending:

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	MANUES IN EQUITI	1	1	
			Total	
1		0		1
1	Balance at Beginning of Year, as Previously Reported	\$	(678,156)	1
2	Restatements (describe):			2
3	AUDIT ADJUSTMENTS		(13,686)	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	(691,842)	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		(808,693)	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	(	)	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	(808,693)	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	(1,500,535)	24

<sup>\*</sup> This must agree with page 17, line 47.

**Ending:** 

12/31/00

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

# 0043547 **Report Period Beginning:** XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 1,891,533	1
2	Discounts and Allowances for all Levels	(394,483)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,497,050	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	797	13
14	Non-Patient Meals	114	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,998	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,909	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26		\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,501,959	30

	o agamet expense	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	443,755	31
32	Health Care	880,788	32
33	General Administration	330,162	33
	B. Capital Expense		
34	Ownership	619,364	34
	C. Ancillary Expense		
35	Special Cost Centers	36,583	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,310,652	4(
41	Income before Income Taxes (line 30 minus line 40)**	(808,693)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (808,693)	4.

- This must agree with page 4, line 45, column 4.
- Does this agree with taxable income (loss) per Federal Income **EXTENDED** If not, please attach a reconciliation. Tax Return?
- \*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

<sup>\*\*\*\*</sup>Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

3

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,677	13,623	252,041	18.50	3
4	Licensed Practical Nurses	4,665	5,443	90,595	16.65	4
5	Nurse Aides & Orderlies	25,157	29,350	306,081	10.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,044	2,385	23,371	9.80	9
10	Activity Assistants	340	397	3,786	9.54	10
11	Social Service Workers	768	896	27,030	30.17	11
12	Dietician					12
13	Food Service Supervisor	1,787	2,085	24,947	11.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,840	12,647	112,629	8.91	15
16	Dishwashers					16
17	Maintenance Workers	935	1,091	11,518	10.56	17
18	Housekeepers	8,453	9,862	76,595	7.77	18
19	Laundry	2,043	2,384	14,740	6.18	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	3,050	3,558	22,194	6.24	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,157	3,683	33,041	8.97	31
32	Other Health Care(specify)			ŕ		32
33	Other(specify)					33
	TOTAL (lines 1 - 33)	74,916	87,402	\$ 998,568 *	\$ 11.43	34

<sup>\*</sup> This total must agree with page 4, column 1, line 45.

# **B. CONSULTANT SERVICES**

<b>D.</b> C	ON GERMAN SERVICES	1	2	3	
		Number	<b>Total Consultant</b>	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	MONTHLY	\$ 2,812	1.3	35
36	Medical Director	MONTHLY	7,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	MONTHLY	3,300	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	1,345	11.3	44
45	Social Service Consultant	MONTHLY	1,031	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 16,288		49

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#### C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	262	\$ 11,805	10.3	50
51	Licensed Practical Nurses	55	1,131	10.3	51
52	Nurse Aides	707	22,966	10.3	52
53	TOTAL (lines 50 - 52)	1,024	\$ 35,902		53

<sup>\*\*</sup> See instructions.

STATE OF ILLINOIS

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**Report Period Beginning:** 

01/01/00

\*\*See instructions.

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**Ending:** 12/31/00

XIX. SUPPORT SCHEDULES D. Employee Benefits and Payroll Taxes F. Dues, Fees, Subscriptions and Promotions A. Administrative Salaries Ownership Description Description Name **Function** % Amount Amount Amount **Workers' Compensation Insurance IDPH License Fee** \$ 36,666 **Unemployment Compensation Insurance Advertising: Employee Recruitment** 8,804 6,104 **Health Care Worker Background Check FICA Taxes** 67,544 **Employee Health Insurance** (Indicate # of checks performed 160 **Employee Meals** PROF DUES/LICENSES 4,261 Illinois Municipal Retirement Fund (IMRF)\* ADVERTISING - PUBLIC RELATIONS 7,922 PHYSICALS/OTHER EMPLOYEE BEN. (2,740)TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.) B. Administrative - Other **Less: Public Relations Expense** (7,922)**Description** Non-allowable advertising Amount CONTRACT SERV - BUS. OFFICE Yellow page advertising 32,770 **CONTRACT SERV - ADMINISTRATOR** 60,287 TOTAL (agree to Schedule V, TOTAL (agree to Sch. V, \$ 110,274 10,525 line 22, col.8) line 20, col. 8) TOTAL (agree to Schedule V, line 17, col. 3) E. Schedule of Non-Cash Compensation Paid G. Schedule of Travel and Seminar\*\* 93,057 (Attach a copy of any management service agreement) to Owners or Employees C. Professional Services **Description** Amount Vendor/Payee Line# Type **Description** Amount Amount **VARIOUS** LEGAL **Out-of-State Travel In-State Travel** SEMINARS 909 TRAVEL 2,046 Seminar Expense **Entertainment Expense** TOTAL (agree to Schedule V, line 19, column 3) **TOTAL** (agree to Sch. V. (If total legal fees exceed \$2500 attach copy of invoices.) TOTAL 63 line 24, col. 8) 2,955

**Facility Name & ID Number** 

FIRWOOD HEALTH CARE CENTER

<sup>\*</sup> Attach copy of IMRF notifications

**Report Period Beginning:** 

01/01/00

Ending:

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

Facility Name & ID Number FIRWOOD HEALTH CARE CENTER

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year	•		
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

	Name & ID Number FIRWOOD HEALTH CARE CENTER	#	0043547 Report Period Beginning: 01/01/00 Ending: 12/31/00
	ENERAL INFORMATION:		
(1)	Are nursing employees (RN,LPN,NA) represented by a union?  NO	(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified
<b>(2)</b>	Are there any dues to nursing home associations included on the cost report?		in the Ancillary Section of Schedule V?  YES
( )	If YES, give association name and amount.		
		(14)	Is a portion of the building used for any function other than long term care services for
(3)	Did the nursing home make political contributions or payments to a political	(1.)	the patient census listed on page 2, Section B? NO  For example,
(3)	action organization? NO If YES, have these costs		is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
	been properly adjusted out of the cost report?  N/A		a schedule which explains how all related costs were allocated to these functions.
(4)	Does the bed capacity of the building differ from the number of beds licensed at the	(15)	Indicate the cost of employee meals that has been reclassified to employee benefits
	end of the fiscal year? <b>NO</b> If YES, what is the capacity?		on Schedule V. \$ 1 Has any meal income been offset against
			related costs? YES Indicate the amount. \$ 114
(5)	Have you properly capitalized all major repairs and equipment purchases? YES		
( )	What was the average life used for new equipment added during this period?	(16)	Travel and Transportation
		( - )	a. Are there costs included for out-of-state travel?
(6)	Indicate the total amount of both disposable and non-disposable diaper expense		If YES, attach a complete explanation.
(0)	and the location of this expense on Sch. V. \$ 0 Line		b. Do you have a separate contract with the Department to provide medical transportation for
	and the focation of this expense on sen. V.		residents? NO If YES, please indicate the amount of income earned from such a
<b>(7)</b>	Have all costs reported on this form been determined using accounting procedures		program during this reporting period. \$
(1)	consistent with prior reports? YES If NO, attach a complete explanation.		c. What percent of all travel expense relates to transportation of nurses and patients TMMATERI
	in two, attach a complete explanation.		d. Have vehicle usage logs been maintained? YES
(8)	Are you presently operating under a sale and leaseback arrangement? <b>NO</b>		e. Are all vehicles stored at the nursing home during the night and all other
(0)	If YES, give effective date of lease.		times when not in use? YES
	11 1 L5, give effective date of lease.		f. Has the cost for commuting or other personal use of autos been adjusted
(9)	Are you presently operating under a sublease agreement? YES X NO		out of the cost report?  NO - MINOR
()	The you presently operating under a sublease agreement:		g. Does the facility transport residents to and from day training?
(10)	Was this home previously operated by a related party (as is defined in the instructions for		Indicate the amount of income earned from providing such
(10)	Schedule VII)? YES NO X If YES, please indicate name of the facility.		transportation during this reporting period.
	IDPH license number of this related party and the date the present owners took over.		transportation during this reporting period.
	1DI 11 feelise number of this related party and the date the present owners took over	(17)	Has an audit been performed by an independent certified public accounting firm? NO
		(17)	Firm Name:  The instructions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department		cost report require that a copy of this audit be included with the cost report. Has this copy
(11)	of Public Aid during this cost report period.  \$ 34,588		been attached? If no, please explain.
	This amount is to be recorded on line 42 of Schedule V.		if no, piease explain.
	This amount is to be recorded on time 42 of Schedule V.	(10)	Hove all costs which do not relate to the marriage of lang terms core hear - livet-1
(13)	And the second s	(18)	Have all costs which do not relate to the provision of long term care been adjusted out
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V		out of Schedule V? YES
	for an individual employee? NO If YES, attach an explanation of the allocation.	(4.0)	TC - 11 1 1 C
		(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services
			performed been attached to this cost report?  N/A
			Attach invoices and a summary of services for all architect and appraisal fees

STATE OF ILLINOIS

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